Federal Employee's Notice of Traumatic Injury and Claim of Continuation of Pay/Compensation

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers Compensation Program

Employee: Please complete all boxes – 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete boxes 14 A, B, and C and OWCP Use - NOI Code.

Employee Data

1. Name of Employee (last, first, middle)			2. Social Security Number
3. Date of Birth (mo., day, year)	4. Sex ☐ Male ☐ Female	5. Home telephone	6. Grade as of date of injury Level Step
7. Employee's Home Mailing Address (Include city, state, and ZIP Code)			8. Dependents ☐ Wife, Husband ☐ Children under 18 year ☐ Other

Description of Injury

9. Place where injury occurred (e.g., 2nd Floor, Main Post Office Building, 12th and Pine)

10. Date injury occurred Mo. Day Yr.	10(a) ☐ a.m. ☐ p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's Occupation

13. Cause of Injury (Describe what happened and why)

14. Nature of Injury (identify both the injury and the part of body, e.g., fracture of left leg)	a. Occupation Code	
	b. Type code	c. Source code
	OWCP Use – NOI code	

Employee Data

I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that is was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ b. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability to work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ a. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Worker's Compensation Program (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

Statement of witness (Describe what you saw, heard, or know about this injury)

Name of Witness	Signature of Witness		Date Signed
Address	City	State	Zip Code

Form CA-1
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